Illinois Workers' Compensation Commission

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Pat Quinn, Governor *Mitch Weisz, Chairman*

Summary of House Bill 1698

House Bill 1698 was signed into law as Public Act 97-18 on June 28, 2011. Below is a summary of the major provisions of the legislation. The bill became effective immediately upon the signature of the Governor. However some of the provisions of the take effect on later dates, which are noted throughout this summary.

Operation of the Commission

- Provides that the Arbitrators and Commissioners of the IWCC are subject to the Code of Judicial Conduct.

- Provides that terms of all Arbitrators are terminated as of the end of business on July 1, 2011. Current Arbitrators continue to serve until they or their successors are appointed.

- Provides that the Governor shall appoint all Arbitrators, subject to advice and consent of the Senate, for the initial terms immediately after the effective date of the Act. The Governor shall request recommendations from Workers' Compensation Advisory Board regarding appointing these Arbitrators, which the Board may provide. These appointments shall be staggered between 1, 2, and 3 year terms. Thereafter, Arbitrators are appointed for 3-year terms by the full Commission. The Governor's appointing authority supersedes provisions of the Personnel Code.

- Requires that all new Arbitrators, not currently serving on the effective date of the Act, must be licensed to practice law in Illinois and must keep that status current throughout their term(s) of service.

- Provides that the Chairman shall evaluate the performance of all Arbitrators annually and make recommendations about reappointment of Arbitrators to the full Commission.

- Expands the current substantive training requirements for Arbitrators and Commissioners to include training on the following topics: professional and ethical standards, detection of fraud, evidence-based medical treatment, and Coal Workers' Pneumoconiosis. Specifies that Arbitrators and Commissioners are to receive at least 20 hours of training every 2 years while in office

- Requires that at least 3 Arbitrators be assigned to each hearing site and cases must be randomly assigned to them. Arbitrators may not serve more than 2 years of any 3-year term in any single county, other than in Cook.

- Provides that all claims of current or former employees of the Illinois Workers' Compensation Commission be adjudicated by certified independent Arbitrators not employed by the Commission. Arbitrators shall be selected by the Chairman from a list generated by the Commission Review Board. Decisions of the independent Arbitrator shall become a decision of the Commission but are subject to judicial review in circuit court.

- Provides that the terms of members of the Workers' Compensation Advisory Board are terminated immediately and the Governor shall make new appointments within 30 days.

Substantive Changes to the Workers' Compensation Act

- Codifies that the Petitioner has the burden of proving by a preponderance of evidence that the injuries arose out of and in the course of employment.

- Provides that for accidents on or after 9/1/11, wage differential awards shall be effective only until the petitioner reaches the age of 67 or 5 years after the date of the award becomes final, whichever occurs later.

- Reduces Temporary Partial Disability (TPD) benefits by using the "gross" rather than "net" amount of income earned from the light duty position.

- Allows employers to establish preferred provider programs (PPP) approved by the Department of Insurance. The PPP's will contain a network of medical providers for the treatment of work-related injuries. The PPP only applies to cases in which the PPP was already approved and in place at the time of the injury. The employee must be notified of the PPP on a form promulgated by the Workers' Compensation Commission. Employees have

2 choices of treating providers from within the employer's PPP network. If the Commission finds that the second choice of physician within the network has provided inadequate or improper treatment, the employee may choose a physician from outside the network at the employer's expense. Employees may opt out of the PPP in writing at any time, but such action forfeits one of their two choices of physicians. If an employee chooses non-emergency treatment prior to the report of an injury, that constitutes a choice of physician.

- Caps repetitive Carpal Tunnel Syndrome awards to 15% of the loss of the use of a hand unless the petitioner proves greater disability by clear and convincing evidence, at which time the award is capped at 30% loss of the use of the hand.

- Provides that to determine Permanent Partial Disability ("PPD") for accidents occurring on or after September 1, 2011, the Commission shall consider the following factors: the impairment report, the occupation of the petitioner, the age of the petitioner, the future earning capacity of the petitioner, and evidence of disability in the treating providers' medical records. The relevance and weight of factors in addition to the impairment report shall be included in all decisions relating to PPD. A physician submitting an impairment report shall use the most recent version of the American Medical Association's "Guides to the Evaluation of Permanent Impairment."

- For accidents on or after September 1, 2011, precludes compensation if the employee's intoxication was the proximate cause of his injury or if the employee's level of intoxication was sufficient to constitute a departure from employment. Establishes criteria for testing and sets a presumption of causation because of intoxication at a Blood Alcohol Concentration of .08, evidence of impairment due to ingestion of cannabis or a controlled substances, or refusal to submit to a test. An employee may rebut the presumption by proving intoxication was not the proximate or sole cause of the injury by a "preponderance of admissible evidence."

Medical Fee Schedule

- Reduces all current fee schedules by 30% for all treatment performed on or after September 1, 2011, and reduces the current 76% percent of charge default to 53.2%.

- Effective January 1, 2012, collapses the current 29 Geozips to 14 zones for hospitals and 4 for physicians and other providers. These zones are based on the boundaries of specified counties.

- Effective January 1, 2012, allows the Commission to update CPT codes and crosswalks based on most recent AMA criteria and to incorporate associated rule changes.

- Effective January 1, 2012, allows the Commission to annually include new procedures in the fee schedule based on non-Medicare relative values and conversion factors.

- Provides that medical implants shall be reimbursed at 25% over invoice price plus actual and customary shipping, minus any rebates.

- Specifies that accredited Ambulatory Surgical Treatment Facilities are reimbursed under the schedule as well as licensed Ambulatory Surgical Treatment Centers.

- Effective June 28, 2011, adds prescriptions filled and dispensed outside of a licensed pharmacy to the fee schedule. These products shall be reimbursed at fee schedule that shall not exceed Average Wholesale Price (AWP) plus a dispensing fee of $4.18. AWP or its equivalent as registered by the National Drug Code shall be set forth for that drug on that date as published in Medispan.

- Adds dental services to the medical fee schedule.

- Requires payers to inform providers of insufficient information in billing within 30 days and imposes the 1% monthly interest fee after 30 days, rather than 60 days.

- Specifies that bills for treatment deemed to be unnecessary or excessive are subject to the prohibition against billing to the injured employees.

- Requires the Department of Insurance of establish rules for electronic billing for all medical bills by January 1, 2012, which must be accepted by all employers/insurers by June 30, 2012.

- Provides that out-of-state services be paid at the lesser rate of that state's medical fee schedule or the fee schedule in effect for employee's residence.

Utilization Review (applies to treatment provided on or after 9/1/11)

- Requires providers to submit to reasonable written Utilization Review (UR) requests, and to make reasonable efforts to submit timely and complete reports to support a request for certification of requested treatment. If such reasonable efforts are not made, the charges may not be compensable or collectable.

- Requires that written notices of certification and non-certification of requested treatment, including evidence-based guidelines, shall be furnished to the provider and employee.

- Provides that an employer or its agent can only deny requested medical treatment because that the treatment is excessive or unnecessary based on a valid UR report.

- Provides that if an employer or its agent refuses to pay for services based on a legitimate UR review, the petitioner has the burden of establishing that variance with the guidelines are warranted in the particular situation.

- Requires a physician performing UR to be available for deposition in this state either in person or through telephonic communication. The cost of such depositions shall be borne by the employer/insurer.

- Requires UR reports be addressed in any written decision.

Insurance Compliance

- Provides that all Employee Leasing Companies provide the Commission with names of all clients that are named under their workers' compensation insurance and copies of the certificates of insurance naming such clients.

- Allows an investigator with the insurance compliance division of the Commission to issue citations between $500 and $2,500 against employers who are in noncompliance with the requirement to maintain workers' compensation insurance. The employer must pay the fine and provide proof of insurance within 10 days of the citation.

Fraud

- Provides that the Department of Insurance has authority to subpoena medical records pursuant to an investigation of fraud and amends the Code of Civil

Procedure to specify that physicians may disclose medical records pursuant to such a subpoena.

- Provides that all reports of fraud not forwarded for prosecution shall be destroyed after the statute of limitations has run on the reported actions.

- Specifies that intentional submission of medical bills for services not rendered constitutes workers' compensation fraud.

- Requires the fraud unit to refer any violation to the Special Prosecution Bureau of the Office of the Attorney General.

- Sets penalties for workers' compensation fraud based on the amount of money involved in the attempted fraud, from a Class A misdemeanor (less that $300) to a Class 1 felony (more than $100,000). Requires restitution be ordered in workers' compensation fraud cases.

- The fraud unit shall procure software to identify waste and fraud, and shall make annual reports on instances of fraud and prosecution to the General Assembly, Governor, Director of Insurance, and Chairman of the Commission.

Miscellaneous

- Allows the Director of Central Management Services ("CMS") to implement a system including purchasing workers' compensation insurance or hiring a third party administrator to administer claims of State employees.

- Establishes the State Workers' Compensation Program Advisory Board within CMS to review, assess, the workers' compensation program involving State employees, and to advise CMS regarding improvements to the system. The board shall consist of 5 voting members, one appointed by the Governor who serves as Chairman, and one each by the four legislative leaders. The board also includes non-voting *ex officio* members consisting of the Chairman/Director/Secretary, or their designees, of CMS, the Attorney General, Department of Insurance, Department of Transportation, Department of Corrections, Department of Human Services, Department of Revenue, and the Commission. They shall meet at least three times per year and submit an annual written report to the Governor, General Assembly, and CMS with recommendations for improving the State workers' compensation system.

- Establishes a pilot program for collectively bargained workers' compensation alternative dispute resolution involving 2 unions designated by the Department of Labor and employers in the construction industry. Certain elements must be in the agreements which must be approved by the Chairman of Commission. An approved plan shall be recognized as legally binding by the Commission and the Courts. A rejection of an agreement by the Chairman is subject to judicial review. Plan administrators must report all relevant information about claims and awards annually.

- Provides that employers shall pay the full negotiated rate for medical services even if the provider has sold his/her interest for a lesser amount.

- Prohibits commissions or gifts from attorneys practicing before the Commission and clients for referrals. The prohibition does not include splitting fees among attorneys or food or refreshment consumed on the premises or catered not exceeding $75 per day. Violation is a Class A misdemeanor.

- Provides that the Director of Insurance shall direct any workers' compensation advisory rate organization to recalculate their proposed rates based on the provisions of HB 1698 by September 1, 2011. NCCI has completed this recalculation, which called for an 8.8% decrease to advisory rates effective September 1, 2011 until January 1, 2012.

- Requires the Director of Insurance to submit extensive annual reports to the General Assembly, Governor, and the Chairman of the Commission about work accidents, all aspects of the workers' compensation insurance market in Illinois, and numerous other matters relating to claims, awards, and medical expenditures. The legislation specifies 34 specific areas the report must address.